

We would like to welcome you to our practice. Please bring your **completed forms, insurance card(s), and driver's license** to your appointment. Patients who arrive with incomplete forms may be asked to reschedule.

If you have not already provided your current insurance information, please contact our office before your appointment. This helps expedite check-in and ensures we have the correct paperwork prepared. Please note that we verify eligibility only based on the information provided; we do not verify specific insurance benefits.

If you have had an X-ray, CT scan, or MRI within the last year, you MUST bring a CD containing your images and reports to your appointment. Failure to bring the CD may result in your appointment being rescheduled, as not all providers have access to outside imaging systems.

Please be prepared to pay your copay at check-in. To confirm copays and benefits, you should contact your insurance carrier using the member services number on your insurance card. If your insurance requires a referral, it is your responsibility to obtain it before your appointment. Many insurance plans do not issue retroactive referrals or authorizations, and you may be responsible for the full cost of services if seen without an active insurance referral.

Patients without insurance will receive a **10% discount** when payment is made in full on the date of service.

Appointment Policy: If you are unable to keep your appointment, please provide **at least 24 hours' notice** by calling **540-232-8405**.

New Patients that no-show or late cancel are subject to the following:

- \$100 fee for no-show or late cancellation. This is not billable to your insurance and must be paid prior to scheduling another appointment.
- Patients who miss **two consecutive initial appointments** without proper notice may not be permitted to schedule future appointments

Established Patients that no-show or late cancel are subject to the following:

- \$50 fee for no-show or late cancellation. This is not billable to your insurance and must be paid prior to scheduling another appointment.
- Patients who miss **two appointments within a 12-month period** without proper notice may be dismissed from the practice

Late Arrivals

- Patients arriving **more than 10 minutes late** may be asked to reschedule

If you should have any questions, please feel free to contact our clinic at (540) 232-8405.

Thank you for trusting us for your medical care. We look forward to seeing you soon!

Pediatric Patient Medical History

Name _____ Age _____ Date of Birth _____ Today's date _____

Mother/Guardian Name _____ Father/Guardian Name _____

School/Daycare _____ Who referred you? _____

What is the problem that brought you in today? _____

Date or Age Problem Started _____ Is it getting worse/better/unchanged? _____

Have you had any work up/treatment for this before? _____

Have you had any Imaging (X-Ray/US/CT scan/MRI)? _____

Please List all the Health care professionals involved in your care and their address:

Pediatrician/Family Doctor _____

Specialist _____

Specialist _____

Physical Therapist _____

Chiropractor/Manual Therapist _____

Current Medications (include vitamins and herbs):

Allergies - Please describe reaction :

Medical Problems for which you see a doctor:

Previous Surgeries or Hospitalizations (Include date):

Sport(s) Played: _____

Previous traumatic injuries (Concussions, Broken bones, Falls, Stitches): _____

Family History: **Year Born:** **Health Problems:**

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Who do you live with (Include Pets): _____

Have you traveled in the Last year (where/when)? _____

Are you exposed to smoke? Y / N **I am a smoker** _____ Pks/Day **Caffeine?** _____ Cups/Day

_____ **BELOW IS FOR CHILDREN 5 YEARS OLD OR YOUNGER ONLY** _____

BIRTH HISTORY: Born On Time or Early? _____ Birth Weight? _____

Vaginal Delivery or C-Section? _____ Vacuum/Forceps used? _____

Any problems with the delivery? _____ Any Problems with the Pregnancy? _____

Any problems right after birth (ex Jaundice)? _____

_____ **BELOW IS FOR INFANTS 12 MONTHS OLD OR YOUNGER ONLY** _____

Breast Feeding: _____ Minutes every _____ hrs (aprox) **I use a Nipple Shield:** Y / N

Supplementation: After/ During / Before breastfeeding _____ ounces of: breast milk/formula _____

To supplement I use: a bottle S+S syringe at the breast Syringe with finger finger feed no syringe cup feed

List Lactation consultants you are/have seen _____

I breast fed until age _____ **but stopped because** _____

Bottle Feeding _____ Ounces every _____ hrs

Solid foods: I have / have not started solids

Describe any difficulties with eating solids: _____

Patient Name: Last: _____ First: _____ Middle Initial: _____
 Preferred Name: _____ SS#: _____ DOB: _____ Sex: M / F / T
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell#: _____ Work#: _____
 Email address: _____
 Preferred method of communication (circle one): ☐ Voice ☐ SMS/TEXT Message ☐ Email (for appt reminder only)

Marital Status: Married Single Divorced Widowed Partner
 Race: African American American Indian Asian White Hispanic Pacific Islander Other
 Ethnicity: Hispanic Non-Hispanic Prefer Not to Report Preferred Language: _____
 Primary Care Physician: _____ Phone: _____
 Referring Physician: _____ Phone: _____
 Occupation: _____ Employer: _____
 Student Status: Full Time / Part Time Location/ School: _____

Responsible Party Info: (if patient is a minor):
 Name: _____ SS#: _____ DOB: _____
 Relation to Patient: _____ Home #: _____ Cell #: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Is this a foster child? Yes / No If yes, Primary Caregiver/Legal Guardian's Name: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____

Do you have Medical Insurance? Yes / No
 Primary Insurance Company: _____
 Policy Holder Name: _____ DOB: _____ Relationship: _____
 Policy Holder's Info: (if different from the patient):
 Address: _____ City: _____ State: _____ Zip: _____
 Secondary Insurance Company: _____
 Policy Holder Name: _____ DOB: _____ Relationship: _____
 Policy Holder's Address: (if different from the patient):
 Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Location: _____

Patient / Legal Guardian Signature: _____ Date: _____

Consent for Treatment

I hereby consent to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of VSOM may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Initials: _____

Notice of Privacy Practices

I acknowledge that I have access to a copy of VSOM Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used. I understand no authorization is required from me for VSOM to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. (If you would like a copy of VSOM's Privacy Practices, please ask the receptionist.)

Initials: _____

Acknowledgement of Deemed Consent for HIV / Hepatitis B or C Virus Blood Testing

Virginia Law authorizes health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to body fluids (ie: needlestick) of a patient in a manner which may transmit HIV or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for these antibodies pursuant to this provision, the testing would be explained, and the testing would be explained, and you would be given the opportunity to ask any questions you might have. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

Initials: _____

Payment Agreement

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by VSOM on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to VSOM (assignment of benefits). I understand and agree that I am financially responsible for all deductible amount s, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions (referrals) necessary for insurance or health benefits.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by VSOM and agree to pay for said medical services according to such terms.

Initials: _____

Self-Pay Agreement

I agree to pay for medical services rendered at VSOM at the time services are rendered. I understand that there may be a payment plan available at my request.

Initials: _____



Patient Name: _____ DOB: _____

Authorization to Treat in Absence of Parent or Guardian (optional)

If my child(ren) is/are brought to the office by _____, I consent for my child(ren) to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child(ren) cannot be seen at VSOM without myself or another legal guardian present.

Initials: _____

Authorized Person(s) for Protected Health Information Disclosure

I hereby authorize VSOM to disclose my medical and Protected Health Information to the person(s) indicated below:

Name

Relationship

Phone #

Initials: _____

Authorization for Release of Confidential Health Care Information

This authorizes VSOM to request and receive from the Virginia Department of Health Professions all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (VSOM). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Initials: _____

Notification of Appointments /Treatments

VSOM makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, VSOM may call home, cell or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided, and may consist of leaving messages on voicemail, email, letters, etc.

By signing below, you are giving permission for VSOM to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Initials: _____

Late Cancellation and No-Show Policy

Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

Late Cancellation and No-Show Policy:

- A late cancellation is defined as failure to contact the office at least 24 hours in advance to cancel the appointment. There will be a \$50 charge for late cancellations all patients. This is not billable to the insurance and must be paid prior to scheduling another appointment.
- A no-show is defined as missing a scheduled appointment. There will be a \$50 charge for no-show appointments. This is not billable to the insurance and must be paid prior to scheduling another appointment.
- NEW PATIENTS who miss TWO consecutive initial office without giving the office at least 24-hour notice may not be permitted to schedule another appointment.
- ESTABLISHED patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

Late Arrivals Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but is not always an option.

Initials: _____

Consent for Use of AI-Assisted Documentation or Medical Scribe Services

I acknowledge that, as part of my medical care, my physician or other clinical staff may use a secure artificial intelligence (AI)-assisted documentation tool and/or a professional medical scribe to assist with creating my medical record during my visit. I understand that these tools are used solely to support clinical documentation and do not replace my provider's professional judgment or responsibility for my care. I acknowledge that all information obtained during my visit is considered Protected Health Information (PHI) and is used, disclosed, and safeguarded in accordance with the Health Insurance Portability and Accountability Act (HIPAA), the HITECH Act, and applicable Virginia state privacy laws. I understand that I may ask questions about the use of these tools and may decline their use by notifying clinic staff.

☐ **Consent and Acknowledge** ☐ **I decline the use of AI-assisted documentation and/or medical scribe services**

Initials: _____

VSOM Notice

VSOM is a teaching facility. This practice is a place where medical students come to learn how to be doctors. It is important for them to talk to people about their health and illnesses. This helps them understand how illnesses affect people and how they cope. We would be grateful if you could help us in this teaching. However, this is entirely voluntary. No one will mind if you would rather not see a student, change your mind, or want the student to leave at any time. You can also refuse to see particular students, such as those of a different sex or those you have met outside of the practice. Of course, the care provided to you by the practice will not be affected in any way. By signing this section, I understand my rights as a patient regarding medical students being involved in my care. I also understand that said medical students and physicians may use my medical information (may include but is not limited to medical notes, x-ray, photo, ultrasound) may be de-identified and used for the purpose of case presentations, lectures, poster presentations or papers for further teaching.

Initials: _____

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes ____ No ____

Please note: If you answered yes to the above question, it is the policy of VSOM that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.

Patient / Legal Guardian Signature: _____ **Date:** _____